Louisiana Medicaid
Progestational Agents

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request authorization for non-preferred progestational agents.

Additional Point-of-Sale edits may apply.

*These agents may have **Black Box Warnings** and/or may be subject **to Risk Evaluation and Mitigation Strategy (REMS)** under FDA safety regulations. Please refer to individual prescribing information for details.*

Approval Criteria for Initial and Reauthorization Requests

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- The requested medication has been prescribed for an approved diagnosis (if applicable); **AND**
- **ONE** of the following is required:
    - The recipient has had a *treatment failure* with at least one preferred product; **OR**
    - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
    - The recipient has *documented contraindication(s)* to the preferred products that are appropriate to use for the condition being treated; **OR**
    - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
    - The prescriber states that the recipient is currently using the requested medication; **AND**
- By submitting the authorization request, the prescriber attests to the following:
    - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
    - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
    - The recipient has no concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling; **AND**
- If the request is for the *non-preferred* hydroxyprogesterone caproate (Generic by ANI; Generic by Mylan) that is **NOT** the generic for Makena® and **NOT** indicated for pre-term labor, **ALL** of the following are required:
    - The prescriber attests that the recipient is a non-pregnant woman; **AND**
    - The recipient must have **ONE** of the following diagnoses:
        - advanced adenocarcinoma of the uterine corpus (Stage III or IV); **OR**

- amenorrhea (primary or secondary) and abnormal uterine bleeding due to hormonal imbalance in the absence of organic pathology, such as submucous fibroids or uterine cancer; **OR**
- medication must be used as a test for endogenous estrogen production and for the production of secretory endometrium and desquamation**.**

Duration of initial and reauthorization approval: **6 months**

References

Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; https://www.clinicalkey.com/pharmacology/

DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey L. eds. Pharmacotherapy: A Pathophysiologic Approach, 10e New York, NY: McGraw-Hill; https://accesspharmacy.mhmedical.com/book.aspx?bookid=1861

Revision / Date	**Implementation Date**
Single PDL Implementation	May 2019
Formatting changes; removed POS wording / April 2021	July 2021